CLELIAN HEIGHTS SCHOOL
135 CLELIAN HEIGHTS LANE
GREENSBURG, PA 15601

IN ACCORDANCE WITH HEMPFILED AREA SCHOOL DISTRICT MEDICATION ADMINISTRATION POLICY

MEDICATION ADMINISTRATION DIRECTIVE

Clelian Heights requests that medication be taken prior to or after SCHOOL hours whenever possible.
If it is absolutely necessary that medication(s) be given during the scheduled SCHOOL DAY, please complete below.

_____DATE OF BIRTH _____AGE_____
Name of Student

THE SECTION BELOW IS TO BE COMPLETED BY THE PRESCRIBING PHYSICIAN

MEDICATION: _____DIAGNOSIS/REASON PRESCRIBED: _____

DOSE: _____ ROUTE: _____ TIME(S) TO BE ADMINISTERED: _____ _____
The "TIME to be given MUST be on the prescription bottle. The nurse cannot accept "at lunch time" or "in the morning" or "twice a day".

LENGTH OF TIME: _____DAYS _____MONTHS _____INDEFINITELY

SIDE EFFECTS: _____

SPECIAL INSTRUCTIONS: _____

PHYSICIAN NAME: _____PHONE # _____
PLEASE PRINT
PHYSICIAN SIGNATURE: _____ DATE_____

THE SCHOOL NURSE MAY CONTACT/CALL THE PHYSCIAN AS NECESSARY

PARENT/GUARDIAN RELEASE OF LIABILITY

I, the parent and/or legal guardian of _____, enrolled at
(STUDENT'S NAME)
_____realizing the importance of administering medication to
(SCHOOL NAME)
my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their giving my child the medicine as prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize the ramifications and thoroughly understand the meaning of this statement.

_____ _____
PARENT'S OR GUARDIAN'S SIGNATURE DATE

TELEPHONE # (724) 837-8120 X 1143/**FAX #** (724) 837-6480